Minnesota BOARD OF Nursing

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Website: www.nursingboard.state.mn.us

POST-GRADUATE PRACTICE VERIFICATION

The information and evidence you are asked to provide on this form is authorized by Minnesota Statutes. The data you supply will used to verify completion of 2,080 hours of post-graduate practice for Nurse Practitioners and Clinical Nurse Specialists.

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements. Minnesota Statute 270C.72 requires applicants to provide their Social Security number and Minnesota business identification number on all license applications.

Until you are issued a license, all data submitted on the application, except your name and address are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the application, except social security number, become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

•Type or print clearly •Use black ink •Provide all information •Incomplete applications will be returned •Do not use initials or abbreviations

APPLICANT INFORMATION

This section must be completed by all CNS and CNP applicants.

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
STREET ADDRESS		
CITY	STATE/PROVINCE	ZIP/POSTAL CODE / COUNTRY
EMAIL ADDRESS		
MINNESOTA LICENSE NUMBER ☐ RN _____	BIRTH DATE (mm/dd/yyyy)	GENDER ☐ Male ☐ Female
UNITED STATES SOCIAL SECURITY NUMBER Required by Minn. Stat. Sec. 270C.72 ___ - ___ - ____	☐ I do not have a US Social Security number at this time but will notify the Board if/when I obtain a US Social Security number	MINNESOTA BUSINESS IDENTIFICATION NUMBER Required by Minn. Stat. Sec. 270C.72

Complete the Affidavit of Post-Graduate Practice Completion section or the Verification of Completion of Post-Graduate Practice section.

AFFIDAVIT OF POST-GRADUATE PRACTICE COMPLETION

This section must be completed by an APRN who was on the Minnesota APRN Registry as of July 1, 2014.

I affirm that I have completed 2,080 hours of post-graduate practice and was listed on the Minnesota APRN Registry as of July 1, 2014.

The undersigned does hereby affirm that the statements contained in this application are true and correct.

_____ _____
Print Name Date (mm/dd/yyy)

_____
Legal Signature

-over-

INITIATION OF PRACTICE

This section must be completed by an individual who is initially entering into practice as a Nurse Practitioner or Clinical Nurse Specialist. Provide information about the hospital or integrated clinical setting in which you are initiating practice below.

NAME OF HOSPITAL OR INTEGRATED CLINICAL SETTING	PHONE
ADDRESS	EMAIL

VERIFICATION OF COMPLETION OF POST-GRADUATE PRACTICE

This section must be completed by a Nurse Practitioner or Clinical Nurse Specialist who has completed 2,080 hours within the context of collaborative agreement within a hospital or integrated clinical setting where advanced practice registered nurses and physicians work together to provide patient care. Complete the actual completion date.

☐ I have completed 2,080 hours of APRN practice within the context of a collaborative agreement within a hospital or integrated clinical setting

COMPLETION DATE (mm/dd/yyyy)

_____ _____
Print Name Date (mm/dd/yyy)

_____
Legal Signature

_____ _____
Print Name of APRN or MD for Collaborative Agreement Date (mm/dd/yyyy)

_____ _____
Signature of APRN or MD for Collaborative Agreement Date (mm/dd/yyyy)

☐ Physician License Number _____

☐ APRN License Number _____

Return completed form to Minnesota Board of Nursing